Physiatry - Patient History

Patient Name: _____ Today's Date: _____

Patient Phone: _____ Date of Birth : _____ Sex: _____

Current Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Highest Grade Level Complete: _____

Please circle appropriate answer (Y=Yes, N= No)

Tobacco Use:	Y	N	Average Amount/Week: _____
Alcohol:	Y	N	Average Amount/Week: _____
Prescription or Over the Counter	Y	N	Average Amount/Week: _____
Other Drug Use:	Y	N	Average Amount/Week: _____

Work history (please complete even if we are not seeing you for a work-related injury)

Is this injury job related? Y N If so, Date of Injury _____

Occupation at time of injury _____

Employer at time of injury: _____

How long employed by that company: _____

Are you currently working? Y N

Occupation: _____

If not working, when did you last work: _____

Current Employer: _____

At this time, are you receiving:

Workers Compensation Time Loss Benefit:	Y	N
Workers Compensation Medical Benefit:	Y	N
Social Security benefit:	Y	N
Unemployment benefit:	Y	N

Other (Explain): _____

_____

_____

Physiatry - Patient History | Continued

Military history

Branch of Service: _____

Years of Service: _____

Type of Discharge: _____

Any Service Related Disability: Y N

If Yes, Please explain: _____

_____

Do you have a personal history of:			**Family History:** If answering yes, please indicate which family member(s)		
Thyroid:	Y	N	Y	N	
Heart Disease:	Y	N	Y	N	
High Blood Pressure:	Y	N	Y	N	
Diabetes:	Y	N	Y	N	
Stroke:	Y	N	Y	N	
Kidney Disease:	Y	N	Y	N	
Epilepsy:	Y	N	Y	N	
Mental Illness:	Y	N	Y	N	
Cancer:	Y	N	Y	N	
Digestive Disorder:	Y	N	Y	N	
Allergies:	Y	N	Y	N	
Severe or Frequent Headaches:	Y	N	Y	N	
Lung Disease:	Y	N	Y	N	
Hearing Disorder:	Y	N	Y	N	
Visual Disorder:	Y	N	Y	N	
Arthritis:	Y	N	Y	N	

Physiatry - Patient History | Continued

Please list any surgeries, hospitalizations, or serious illnesses you have had and the date:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all medications you are currently taking, dosage how often taken, and the prescribing Doctor:

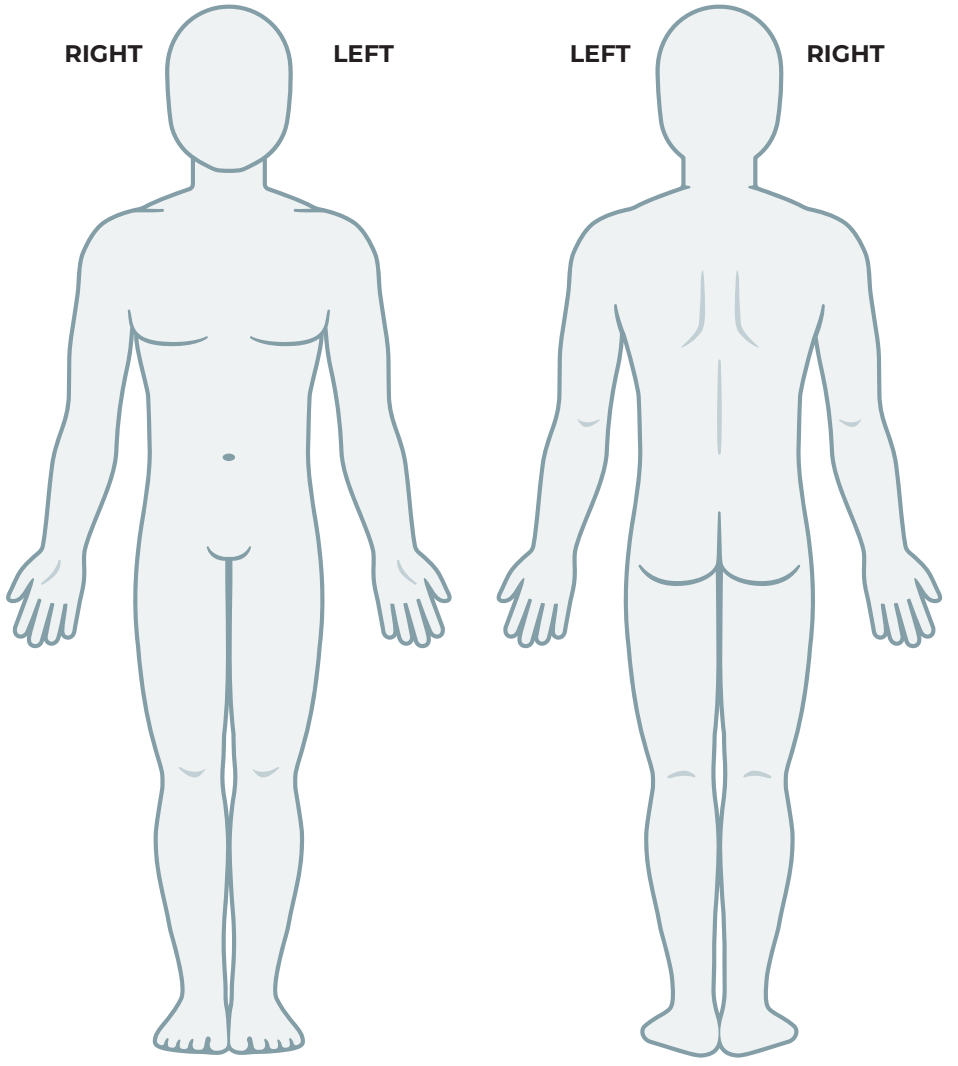
Medication	Dosage	How often	Reason	Prescribing Doctor

Physiatry - Patient History | Continued

Pain Inventory

Please use the key below and mark **all** affected areas on your body where you feel the described sensations, even if you are not being seen for that problem today.

KEY			
////	Stabbing	= = =	Numbness
X X X	Burning	O O O	Pins & Needles



PAIN RATING METRICS	
10+	= Maximal
10	= Very, Very Strong
9	=
8	=
7	= Very Strong
6	=
5	= Strong
4	= Somewhat Strong
3	= Moderate
2	= Weak
1	= Very Weak
0.5	= Very, Very Weak
0	= Nothing At All

PAIN RATING REPORT

Now _____

Over past 30 Days:

High: _____

Low: _____

MR: No Pain at all ●—●—●—●—●—●—●—●—●—●—● Pain as bad as it could be

Signature : _____ Printed Name: _____

Date: _____ Date of Birth: _____